For _____school year
[Expires at the end of August]

PERMISSION TO ADMINISTER MEDICATION AT SCHOOL

Shorecrest High School
Shoreline School District
15342 25th Ave NE
Shoreline, Washington 98155

ATTENTION: Shorecrest School Nurse
PHONE: 206.393.4308
FAX: 206.393.4284
EMAIL: sc.nurse@shorelineschools.org

Student _____ Birth date _____ Grade _____ Age _____

Parent _____ Address _____ Phone _____

Licensed health professional _____ Phone _____ Fax _____

This section to be completed by PARENT or GUARDIAN:

I request that the school nurse, or designated staff member, administer the medication(s) described below as directed by the above licensed health professional. I accept responsibility for supplying the medication in the original container, and for immediately notifying the school nurse (or principal) of any change in these instructions.
☒I give my consent for the confidential information contained on this form to be **FAXED** to the above named school.

_____ _____
Parent/Guardian signature **Date**

This section to be completed by LICENSED HEALTH PROFESSIONAL:

MEDICATION	DOSAGE	ROUTE	TIME TO BE GIVEN

Health condition requiring administration of medication _____

Possible side effects: _____

Other instructions: _____

I request and authorize that the above-named student be administered the above-identified medication as per the instructions indicated above from [dates] _____ to _____ [Not to exceed current school year] as there exists a valid health reason which makes administration of the medication advisable during school hours.

_____ _____ _____
Signature of Licensed Health Professional with Prescriptive Authority * **Name [PRINT OR TYPE]** **Date**

*MD, DO, ARNP, PA-C, DDS, ND
Rev 5/1/19:so